SHBP
State Health Benefit Plan

STATE HEALTH BENEFIT PLAN (SHBP)
2012 RETIREES TOBACCO USERS CESSATION AFFIDAVIT FORM

Policyholder/Plan Member Name_____

Social Security Number_____

Health Plan Option: (Circle One) Cigna Standard HDHP, Cigna Wellness HDHP, Cigna Standard HMO, Cigna Wellness HMO, Cigna Standard HRA, Cigna Wellness HRA, UHC Standard HDHP, UHC Wellness HDHP, UHC Standard HMO, UHC Wellness HMO, UHC Standard HRA, UHC Wellness HRA

Check the following:

□ I **hereby certify that all covered members have not used any tobacco products** within the last 60 days. In addition, I have attached a certificate of completion affirming that all covered members that previously used tobacco have completed the telephonic tobacco cessation health coaching program with my healthcare vendor.

OR

□ I **hereby certify that a covered member of my family is unable to achieve tobacco-free status** due to a medical condition and that all other covered members have not used tobacco products within the last 60 days. In addition, I have attached a certificate of completion (from my healthcare vendor) for the telephonic wellness program and I have attached a letter from the treating physician stating the medical reason why the covered member is unable to achieve a tobacco-free status.

Check all of the following:

□ I understand that as a SHBP member I have the responsibility to read the current Decision Guide and the Summary Plan Description (SPD) of my chosen health benefit option.

□ I understand it is my responsibility to access the website **OR** complete a personalized change form each year during the Retiree Option Change Period (ROCP) to make elections and answer the surcharge questions to prevent default surcharges.

□ I also understand that this document must be completed, all boxes checked and returned to SHBP, P.O. Box 1990, Atlanta, GA 30301-1990 in order to remove the tobacco surcharge currently being applied to my health coverage premium. In addition, if I or any covered dependents resume using any tobacco product after completing the telephonic tobacco cessation health coaching program, I will notify SHBP in writing. No refund in premiums will be made for any previous deductions that included the surcharge amounts.

I do hereby attest that the above information is true and correct to the best of my knowledge. I further understand that I will permanently lose my SHBP coverage if I knowingly and willfully make a false or fraudulent statement or representation to the Georgia Department of Community Health (DCH) regarding the information reported on this form or other information pursuant to O.C.G.A. Section 16-10-20.

Signature_____ **Date**_____